

REVISED LETTER - REVISION IN BOLD.

November 4, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.1088.01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Orthopedics.

I am the Secretary and General Counsel of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

Clinical History:

This female claimant suffered an injury on ____, while performing her duties as a jail nurse. She experienced sharp pain localized to the base of her neck and scapular region with some extension down into her hands and was treated conservatively with medication. She experienced no relief of her pain, even with narcotics.

An MRI of the cervical spine on 05/08/02 revealed a 2-3 mm left paracentral HNP at C6-7, which contacted the thecal sac and encroached upon the left neuroforamen. She was hospitalized on 05/16/02 for evaluation and treatment. She was treated with physical therapy and narcotic analgesics.

She was noted to have weakness of the left triceps and decreased triceps reflex. Surgery was proposed by a neurosurgeon due to failure of conservative treatment.

Disputed Services:

Anterior cervical discectomy and fusion.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that without a second opinion from a neurosurgeon at the time of the evaluation, which is usually required for spinal surgery, the requested procedure is not medically necessary at this point in this case.

Rationale for Decision:

The patient had approximately one month of treatment prior to the recommendation for surgery. While the decision for surgery was based on objective neurological findings, intractable pain with radiation to the extremity, and a positive MRI scan, this case would have been better documented and stronger had the patient had a second opinion. It would have been helpful to have documented by **electro-diagnostic** studies some nerve root irritation.

The reviewer noted that at this point in time, approximately five months since her hospitalization, she may have had a more than adequate trial of conservative treatment and her symptomatology should be re-evaluated.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on November 4, 2002.

Sincerely,